

LETTERS *to the Editor*

The Early Cancer Cytopathology and the "Nothing Lesion"

DR. LEWIS GUISS has written an admirable and concise paper "Cancer of the Upper Digestive and Respiratory Tracts."* There are few physicians in Southern California who have committed themselves to and commingled with early cancer, more than Dr. Guiss. Nevertheless, his statement "evaluating visible lesions by examination of exfoliated cells can only be regarded as expensive, inconclusive, and responsible for delay in beginning therapy," deserves direct and distinct dissent. He has understated the "nothing cancer," and left oral cytology with but faint praise.

Possibly the greatest breakthrough in modern clinical cancer awareness is the fundamental realization that early epithelial cancer is undetectable by the medical eye. This *in situ* carcinoma generally remains undetectable through the greater part of its biologic life. Any definition or basic concept of early cancer must refer to and include full awareness of this long, clinically invisible *in situ* stage of epithelial cancer.

Early cancer is highly curable, clinically innocuous, or invisible, and susceptible only to sensitive cytological techniques. This is the "nothing stage" of subclinical cancers; stage zero. The suspicious clinical lesion is by biologic definition *not* an early lesion. The early lesion is by definition invisible or nonsuspicious.

How clinically suspicious are the vast majority of *in situ* cancers of the cervix? What gynecologist does not readily admit his grateful dependence on the spectrum of subclinical data offered him by cytologic techniques?

In like manner, *in situ* oral mucosal cancers are: (1) Squamous; (2) *In situ* as long or longer than their squamous cervical cousins, and (3) As undetectable, innocuous and clinically inapparent *in situ* as their cervical counterparts; (4) Require surface cytology for sensitive, accurate cyto-evaluation.

Cancer of the cervix has amply proven that a suspicious lesion is not an early lesion, and an early lesion is inapparent, or, if apparent, clinically considered a "nothing lesion." This "nothing lesion" is detectable by (1) awareness and (2) something to scrape with. By all means, biopsy suspicious lesions. This dictum does not exclude cytologic examination on the "nothing lesion." In the "nothing lesions" rest the pre-suspicious, highly curable cancers. The recent Veterans Administration survey on oral cancer† revealed fully 10 per cent of proven oral carcinoma would not have been scraped had not the survey dictated that all oral lesions were to be studied. In other words, 10 per cent of proven cancers were completely unsuspected by the cancer conscious participating dentists; these are "nothing cancers."

Exfoliative cytology and its impact on detecting occult, inapparent carcinoma, needs emphasis, particularly to our dental colleagues who see so many mouths. Oral cytology, respectfully handled, will bring to dentists heightened awareness of the "soft tissues of the mouth" and bring to oral cancer, a multitude of professional eyes sophisticatedly alert to inapparent, *in situ* cancer. A real delay in early cancer detection rests in the assumption that *biopsy* of suspicious lesions detects *early* cancer.

The future of early cancer detection is cytologic examination of "nothing lesions," be these of the cervix, bronchial, or oral mucosa. I trust and believe Dr. Lewis Guiss can only agree, since he, more than most physicians, is highly aware of and sensitive to, the need for *early* cancer detection. The "nothing" clinical cancer predates the suspicious lesion.

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*Guiss, Lewis, Cancer of the Upper Digestive and Respiratory Tracts, California Medicine 100:271 (1964) April.

†Interim Report of Veterans Administration Cooperative Study of Cytology, U.S. Government Printing Office, Washington, D.C. (1960) Nov.